Stigma and discrimination amongst teachers living with HIV/AIDS

Abstract

Since its inception, the causes of HIV/AIDS have mainly been attributed to indecent and even evil behaviour and has seen victims labelled as social deviants. The origin of HIV/AIDS and its cure has been the primary focus of research in this field. This study examined the stigmatisation and discrimination teachers living with HIV/AIDS, experienced. A narrative inquiry design, located within the interpretative paradigm was used to mine qualitative data via narrative interviews. Qualitative content analysis was used to analyse data, specifically descriptive, process and emotion codes, to develop themes from the data. The key findings indicated that stigmatisation of and discrimination against teachers living with HIV/AIDS are exacerbated by stereotypical beliefs, fear associated with the disease's incurability, perceptions about teachers as sources of information, and other social constructs around the pandemic. This results in these teachers being ostracised, labelled as inferior, and stripped of their status. This leaves them feeling worthless. Recommendations are made for the intensification of consciousness- raising about openness, trust and dialogue to overcome the stigmatisation and discrimination against people living with HIV/AIDS, reducing the myth about the silence and shame around HIV/AIDS, and continuous education on reducing new infections, and supporting those who are infected.

Key words: HIV/AIDS; stigma; discrimination, teachers, pandemic, narrative interviews.

Introduction

The origin of HIV/AIDS and its cure has been the primary focus of research in this field, both within the medical fraternity and elsewhere (Dahlui, Azahr, Bulgiba, Zaki, Oche, Adekunjo and Chinna, 2015). As elaborated by Zuma, Simbayi, Rehle, Mbelle, Zungu, Mthembu, North, Van Zyl, Jootse, Moyo, Wabiri, Maduna, Mabaso, Naidoo, Chasela, Chikovore and the Educator Survey ii Study Team (2016), HIV/AIDS research has prompted discussions regarding the need for HIV/AIDS intervention in schools. There has been concern as to what actions can be taken to change the misperceptions regarding the causes of AIDS and how to cure it, since a cure has yet to be found. Researchers in South Africa, and the world over are working tirelessly to find a cure for HIV/AIDS. The quest for answers has seen every sector of society participating in the fight against HIV/AIDS, with the education system regarded as the disseminator of information.

UNAIDS (2016) cites that South Africa has the largest programme, in the world, to treat people living with HIV/AIDS. Nevertheless, Statistics South Africa (2017) highlights a sharp rise in HIV/AIDS prevalence from 4.09 million in 2002 to 5.51million in 2014 and 7 million in 2017, pointing to possibilities that new infections are taking place. Furthermore, Zuma, et al., (2016) reported that the number of teachers living with HIV/AIDS in South Africa is 15, 3% which translates to 58000. This is higher than the 2004 survey which was 12, 7%. This shows that curbing new infections is far from over. These are disturbing statistics considering the urgency to reduce the rate of infections. However, as South Africa approaches the fourth decade of the HIV/AIDS pandemic, Doyal (2016) observe that much progress has been documented in the education of people about HIV/AIDS. Equally important, the advent of antiretroviral treatment has lengthened the lives of people living with HIV/AIDS (Squire, 2013).

However, there is a dire need to contain the spread of HIV/AIDS and manage it because of its effects on those of working age. Teachers in particular, are amongst the worst affected groups (Campion, 2015). Therefore, the effects of HIV/AIDS on education cannot be underestimated.

Fundamental to this study is the understanding that the Gauteng Department of Education is an important regional institution in the province of Gauteng, which has the highest population in the country. The Gauteng Department of Education is labour intensive and the large workforce under its charge gives it significant power to affect the education system. Moyo and Smit (2017) argue that school leadership should be encouraged to question their values, attitudes, and practices as they relate to HIV/AIDS amongst teachers living with HIV/AIDS. Other researchers and planners can gain a better understanding of the strategies that may be employed in various contexts to successfully achieve their goals in this area. This increased knowledge can be utilised in other places to professionally develop those leaders who lag.

The Gauteng Department of Education (GDE) has 2 045 principals leading and managing teachers, 59 175 teachers, 185 8745 learners and 6 237 public service staff in 2 612 ordinary schools (South Africa. Gauteng Department of Education 2016, 3). Evidence from the research carried out on teachers by Zuma et al. (2016) shows that productivity of teachers is intrinsically linked to health and well-being among other factors and people have realised that HIV/AIDS has become detrimental to school productivity. There is a need to create a school climate in which teachers can feel free to discuss their most sensitive issues with their leaders. This is indeed a complex matter, given that school principals are seldom equipped with counselling or debriefing skills. This is further exacerbated people's natural fear of death and their reluctance to discuss HIV/AIDS-related issues and mortality (Mfusi, 2011). Literature shows that

teachers lose respect when infected with HIV/AIDS (Dahlui, et al., 2015). Furthermore, people make moral judgements of infected people and have preconceived ideas about their sexual behaviour (UNAIDS, 2017).

Stigma and discrimination pose a huge challenge to people living with HIV/AIDS and to the people around them. In this regard Cuca, Asher, Okonsky, Kaihura, Dawson-Rose and Webel (2017) explain the harmful effects of stigma and discrimination on people living with HIV/AIDS. They cite studies that have been conducted in South Africa showing that people living with HIV/AIDS are afraid of disclosing their status because of fear of stigma and discrimination. UNAIDS (2017) estimates that one in every eight people living with HIV/AIDS is being denied health services in South Africa because of stigmatisation and discrimination.

It is against this background that this study sought to explore the stigmatisation and discrimination teachers living with HIV/AIDS in Gauteng Province in South Africa, experienced. More specifically, the study aimed to understand how teachers living with HIV/AIDS experience stigmatisation and discrimination. Additionally, the study sought to gain insight into the causes and effects of stigmatisation and discrimination on teachers living with HIV/AIDS. Hence the following research questions were addressed; 1) what are the causes of stigmatisation and discrimination? 2) How do teachers living with HIV/AIDS experience stigma and discrimination? 3) How do stigmatisation and discrimination affect teachers living with HIV/AIDS?

The following section provides review of related literature, followed by a discussion of the two theories underpinning this study. Thereafter, a presentation of research design and methodology, results and discussion followed by conclusion and recommendations.

Review of literature

Since its inception, the causes of HIV/AIDS have mainly been attributed to indecent and even evil behaviour that has seen victims labelled as social deviants (Johnson and Naidoo, 2017). Therefore, it cannot be denied that teachers living with HIV/AIDS suffer the consequences of stigmatisation and discrimination. Given the prominence of HIV/AIDS-based stigmatisation and discrimination, this study deems it significant to examine the manner in which it manifests itself within the teaching profession.

Cultural and Moral Beliefs

Society believes that people living with HIV/AIDS have been infected because of their own irresponsibility. Sexual promiscuity has long been viewed as a primary cause of infection and those infected people are viewed as deserving of punishment (Avert, 2016). These notions regarding the sinfulness of deviant sexuality and immorality (UNAIDS, 2017) are believed to be contributory factors to stigmatisation and discrimination.

The different ways in which people perceive HIV/AIDS hinges on beliefs that the pandemic is a life-threatening disease caused by immoral behaviour and that infected people are invading healthy societies (Kamau, 2012). The stereotyped beliefs (Dahlui, et al., 2015) lead to the ostracism of people living with HIV/AIDS (PLWHA). The reality that AIDS is incurable, the immorality currently associated with the way in which it is acquired, and the assumption that it is a just punishment for said immorality, subdue PLWHA, causing them to feel victimised (Johnson and Naidoo, 2017).

Fear of infection

A high degree of fear surrounds the HIV/AIDS pandemic. The fear of contracting HIV through daily contact with people who are HIV-positive (UNAIDS, 2016) creates a barrier between those who are infected and those who are not. People who are infected are relegated to the margins of society. The anxiety caused by fear of contagion and other negative attributes assigned to PLWHA further exacerbate the stigmatisation associated with HIV/AIDS (Avert, 2016). Society reacts to the HIV/AIDS pandemic intensely because it is life threatening. This combination of fear, and the perception of HIV/AIDS sufferers as somehow tainted, manifests as stigmatisation, resulting in ostracism, avoidance and isolation, with people distancing themselves from PLWHA.

The fear surrounding the emerging HIV epidemic in the 1980s largely still persists today, as observed by Michel Sidibé Executive Director of UNAIDS in UNAIDS (2017). HIV/AIDS is connected to those groups of people who have traditionally been marginalised. People living with HIV/AIDS are classified as belonging to the marginalised groups since HIV/AIDS is associated with prostitutes, promiscuous people, and homosexuals (Rispel, Cloete and Metcalf, 2015). Fear increases amongst PLWHA as they avoid the labels associated with the pandemic and the social baggage that comes with them. This may lead to the deterioration in teachers' morale at work as they are likely to experience self-judgement resulting in shame, worthlessness, and being stereotyped (UNAIDS, 2017).

Social constructions

Social processes have the potential to disempower people and cause PLWHA to withdraw from society. As Kamau (2012, 1) elaborates: "Since the onset of HIV in the 1980s, a similar social construction of stigma has been directed at PLWHA who by

possessing HIV/AIDS are perceived to be different and therefore undesirable". School life suffers most because of its role in the community. Furthermore, Dahlui et al. (2015) observe that teachers lose the respect of members of the community when infected with HIV/AIDS. People develop negative attitudes and prejudices towards PLWHA, which manifest as verbal abuse, social discrediting and discrimination, all of which affect the infected person's ability to live positively (UNAIDS, 2017). Chan, Tsai and Siedner (2015) caution that these attitudes cause people who are HIV-negative to acquire dominant social status over those who are infected.

It is beyond doubt that HIV/AIDS-related stigmatisation and discrimination are socially constructed. Theoretical literature shows that stigma does not only emanate from a fear of physical contagion but also from a fear of symbolic contagion (Cuca, et al., 2017). Gradually, society is being classified into two different groups, that is, those who are living with HIV/AIDS and those who are HIV negative. The complicacy linked to the welfare of people in a community that is unequally segmented causes a considerable number of groups to be devalued in order for other groups to appear superior (Aulette-Root, Aulette and Boonzair, 2013). The feelings of inferiority result in a sense of hopelessness for PLWHA.

It is difficult for HIV-positive teachers to survive in this context, especially given that they are expected to be role models and custodians of knowledge. It may be difficult for them to proclaim their roles as major players in the education system. Society stereotypes these groups and individuals and ascribes negative characteristics to them, perceiving them as misfits and social deviants (Johnson and Naidoo, 2017).

Lack of information and prejudices

As HIV/AIDS continues to wreak havoc on humankind, Van Dyk (2012) observes that the tendency of society towards moral judgements and assumptions regarding the sexual behaviour of HIV-infected people has increased. Such attitudes stem from the responses based on moralising attitudes and a lack of knowledge (Rispel, Cloete and Metcalf, 2015). In other communities, PLWHA may be regarded as bringing disgrace to families and communities (ibid, 2015).

In this study, teachers may find themselves in a work environment with professionals who are well informed about HIV/AIDS-related issues, but within a surrounding community wherein people prejudge HIV-positive teachers. The reason for such judgements against teachers could be as a result of the expectations of the professionals with whom their children spend the greater part of their day. Stigmatisation and discrimination is a reality for PLWHA.

Theoretical framework

The transformational leadership and an ethics of care framed this study. The two theories formed the lens through which the data was collected, analysed and discussed. The theoretical insights offered by transformational leadership theory was chosen because according to Bush (2008) it provides followers with a compelling vision through a strong role model that followers can trust. In addition, transformational leadership has been described as powerful and the ideal type of leadership for transforming a rapidly challenging environment (ibid). The transformational leadership theory is developmental and seeks to involve every individual in the organisation. Principals facilitate behavioural change (Bush, 2012b; Bass, 1997; Begley, 2010; Mahabeer, 2008). Aside from modelling effective leadership behaviour for teachers, principals also increase their followers' motivation levels if they are to keep their school

communities abreast of the changes brought about by HIV/AIDS (Moyo and Smit, 2017). The way in which principals react to teachers living with HIV goes a long way to altering the perceptions around HIV/AIDS issues. Since leaders take individual needs into consideration (Bass, 1997), principals can create a supportive environment for teachers living with HIV.

To this end, Perumal (2015a; and Perumal 2015b) argues that the rights of teachers are mapped on the blind spots of the human rights discourse and are subject to symbolic and sometimes physical violence. Teachers living with HIV/AIDS are vulnerable and dependent on principals for support. Principals are morally compelled to attend to sick teachers' needs and challenges. Thus, Held (2006, 10) posits: "The central focus on the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibilities". Teachers living with HIV are in particular need of such care. Therefore the two theories argue that principals as leaders create a supportive environment where teachers living with HIV are free to disclose their status based on trust and caring relationships.

Research design and methodology

A qualitative approach, embedded in the interpretative paradigm, was followed to examine the stigmatisation and discrimination on teachers in schools in the Gauteng province of South Africa. Qualitative research mine rich descriptions that cannot be represented by numerical data. As such, McMillan and Schumacher (2010) hold that nothing escapes scrutiny or is taken for granted in the qualitative researcher's detailed approach to description. More importantly, qualitative researchers attempt to understand the complex world of lived experiences from the point of view of those who live it (Guba and Lincoln, 1989).

Narrative inquiry is a branch of qualitative research that deals with manners of understanding experience (Given, 2008) and/or how people perceive their own personal experiences (Newby, 2014). Narrative inquiry gives researchers simultaneous access to various situations, in which participants can relate sensitive issues in different social and professional settings (Matthews and Ross, 2010).

Our adoption of narrative inquiry is grounded in the assumption that humans, both individually and socially, lead storied lives (Clandinin, Pushor and Murray Orr, 2007). Most generally, narrative inquiry is situated in the interpretative framework, which consists of researcher and participant subjectivity based on textual material written by the researcher (Wertz, Charmaz, McMullen, Josselson, Anderson and McSpaden, 2011). Human experience is explored and conceptualised in depth via the exploration of participants' lives.

Sampling and site selection

This research study purposively obtained data from eight teachers living with HIV/AIDS in the Gauteng Province of South Africa. The Gauteng Province was chosen because of its proximity to the researchers (Cohen, Manion and Morrison, 2011). Saldana (2011) asserts that purposive sampling is not only restricted by participant selection but also by settings, incidents and events included in data collection. More importantly, Cohen, Manion and Morrison, 2011, 158) argue that purposive sampling is suitable for "hard-to-reach groups including minorities, marginalised or stigmatised 'hidden groups'". This study explores HIV/AIDS-related issues amongst teachers and, according to (Cohen, Manion and Morrison, 2011), people living with HIV/AIDS are among the minority groups that are marginalised, stigmatised and discriminated against.

Data collection

The most appropriate method for data collection was deemed to be narrative interviews, since the primary focus was the most stigmatised disease - HIV/AIDS. Narrative interviews are particularly interested in the stories that participants tell (Kvale and Brinkman, 2009). We chose to gather data via narrative interviews because of this form's ability to extract lived experiences and stories with a distinct plot, detailing social interactions, which unfold temporal order (ibid, 2009). The conversational mode of the narrative interview allowed the interviewees the time and setting to reconstruct their own experiences and realities, in their own words (Yin, 2015).

Given the sensitivity around HIV/AIDS issues, we used what Tracy (2012) refers to the narrative interview as: an open-ended, relatively unstructured interview that facilitates the participants to relate stories. We interacted with participants in relationships, within which we extracted data from them by our shared humanity. The interviews were face-to-face, semi-structured and lasted for 60 minutes. The decision to conduct only person-to-person interviews was again backed by the aim of this research study. The use of open-ended questions in this study facilitated the participants' expressions of their views.

Data analysis

The data were analysed using qualitative content analysis. All the interviews were digitally recorded and transcribed verbatim. Verbatim transcripts were numbered line by line. Data were coded using process, descriptive and emotion codes. These codes were categorised into themes (Saldana, 2011). The themes were based on the individual narratives that were shared by teachers living with HIV/AIDS. Content data analysis enabled narrowing down of the data into themes (Merriam and Tisdell, 2015).

The themes formed a basis that provided insights into stigmatisation and discrimination of teachers living with HIV/AIDS. Accordingly, recommendations were established, as indicated by participants and in the literature that was reviewed.

Trustworthiness

To ensure trustworthiness in this inquiry, Tracy's (2010) model of qualitative research was used. The teacher participants participated voluntarily; confidentiality and anonymity were guaranteed and they signed letters of consent prior the interviews being (Bush, 2012a). For the sake of sincerity, a transparent "audit trail" was made available through referencing data by numbering all the lines of verbatim transcripts. A reflexive journal was maintained. Significant time was spent with participants to enable exploring their experiences beneath the surface (Mertens, 2012). As Stake (2010) asserts, qualitative researchers write about what happened; they do not write fiction. We wrote about what our participants experienced, which Tracy (2010, 41) refers to as *verstehen* (meaning "to understand" in German).

One of the two authors of this study is a teacher who has worked and interacted with teachers living with HIV/AIDS and observed their stigmatisation, hence the interest to undertake this study. The study presented a unique opportunity to explore experiences, as a data collection instrument, understanding the need to recognise and suspend one's own assumptions in order to get into the world of other people, whose lenses and understandings were radically different.

Ethical considerations

This study was approved by the University of South Africa's College of Education Research Ethics Committee and permission was sought from the Gauteng Department of Education to conduct the study. After obtaining approval, access to the teachers and their schools was requested through application letters that indicated that our research was fully endorsed by the University's Research Ethics Committee and the Gauteng Department of Education.

The processes and purposes of the research were explained to the participants. The participants signed letters of consent before the commencement of the interviews and anonymity, confidentiality and voluntary participation were guaranteed (Bush, 2012a). All participants' information and responses solicited during the research process were kept confidential and identities anonymously presented.

Results and discussion

All the participants confided that HIV/AIDS is stigmatised and that those suffering from the disease suffer from discrimination. As articulated by Kouses and Posner (1995), transformational leaders enable others to act, modelling the way and encouraging the heart, challenging the process and inspiring the vision. With transformational leadership, both parties – that is the principals and the teachers – are motivated. Leithwood, Tomlinson, and Genge (1996), Bush (2012b) and Bass (1997) maintain that followers need to feel leadership. A leader who demonstrates professionalism will be looked up to as an example of what is expected. In this regard, Siegel (2009) explains that the caring individual focuses on another person, not out of self-concern but because they are fully engrossed in the reality of the other.

In this study, there was evidence that teachers suffering from HIV/AIDS experience stigma and discrimination. Almost all the participants pointed to stigma and

discrimination as the reasons why disclosing their HIV status is difficult. One of the teachers living with HIV/AIDS shared the following experiences:

> *"Well, I would say discrimination starts at the health facilities. When everyone knows that a certain area or ward is for people living with HIV/AIDS, they attach labels. After my illness I was labelled hot plate by people around me".*

Clearly, stigma and discrimination are common in these schools and have increased the problems faced by teachers living with HIV/AIDS. Revealing similar experiences, one of the teachers made the following comments:

> *"Stigma and discrimination emanate from misconceptions about the causes of HIV/AIDS".*

On the frequently raised topic of stigmatisation and discrimination, Peltzer, Szrek, Ramlagan, Leite and Chao (2015, 159) make the following point, "A prime impact of discrimination is that it pushes the epidemic underground, forcing people who have contracted HIV, and anything else associated with the disease, into hiding". They further explain that it is well documented that PLWHA experience stigma and discrimination on an on-going basis. Similarly, Chan and Tsai (2017) maintain that people living with HIV/AIDS do not only experience medical problems; they are also faced with social problems constructed around the epidemic. In the interviews, the responses of another teacher participant, showed that she felt bitter about being stigmatised and discriminated against, which is characterised by "misconception":

> "*A lot of discrimination and stigma is attached to HIV/AIDS. We are taken to be not capable of performing some duties like sports activities. I am regarded as physically not fit to perform. Sharing the same utensils with other staff members in the staff room has been a problem. Some people still have the notion that the disease is transferrable or rather contagious, which is not the case. The misconceptions of HIV/AIDS needs to be dealt with so that people can focus on*

how to deal with HIV/AIDS. Once people know that you are HIV-positive, they look at you as a wrong-doer".

In keeping with this, Johnson and Naidoo (2017, 76) describe stigmatisation as follows: "[It is an] attribute that is deeply discrediting that reduces the person from a whole and usual person to a tainted, discounted one". People in organisations can purposefully, or carelessly, contribute to the deterioration of other members' ethical ideals (Noddings, 2013). HIV transmission is still widely associated with people's lifestyles and moral values. Renowned people, like the late former South African President Nelson Mandela, have played a crucial role in breaking the silence and eroding the taboo associated with HIV/AIDS. HIV/AIDS has not been treated like any other disease and continues to be the source of serious stigmatisation and discrimination. As Kamau (2012) asserts, that stigmatisation and discrimination of people living with HIV/AIDS is exacerbated by ignorance about the disease, misconceptions about how HIV is transmitted, limited access to treatment, responsive media reporting, incurability of the disease and fears and prejudices relating to socially sensitive issues including sexuality.

As reflected in the data, stigmatisation and discrimination are a challenge. One teacher described her situation thus:

"I have been given names and my colleagues hate me. Due to sensitivity of the issue as well as stigma and discrimination – it is a challenge. Other teachers complain when they have to stand in for absent teachers. It is difficult to stop gossiping… What makes it difficult to disclose is stigma and discrimination."

Stigmatisation and discrimination are highly destructive, especially when coming from people close to the victim. Noddings (2002) and Sander-Straudt (2011) argue that caring should happen naturally, based on the natural desire to do what is good instead

of abstract moral reasoning. Considering this, it is relevant to consider that immoral behaviour has been assumed to be the cause of HIV/AIDS by large sections of society since the disease first emerged (Rispel, Cloete and Metcalf, 2015). This moral issue is the main source of the stigmatisation and discrimination surrounding HIV/AIDS infection. The moral blame placed on people living with HIV/AIDS and those who are close to them has profound roots in the punishment theory (Johnson and Naidoo, 2017). Erroneous stereotypes (Dahlui, et al., 2015) lead to the ostracism of people living with HIV/AIDS. One teacher expressed her frustration in the following words:

> *"Stigma and discrimination are really destroying. People make you to feel guilty; after the stroke I thought I was not going to make it. My sister instilled a positive mind in me. However, there was a time when I felt like giving up".*

The reality that AIDS is incurable, combined with the immorality associated with how it is acquired, results in society victimising people living with HIV/AIDS, and these people consequently become subdued and withdrawn.

In this regard, the literature related to the stigmatisation and discrimination of PLWHA argues that complicacy linked to the welfare of people in a community who are unequally segmented causes a hierarchical power dynamics that act against PLWHA (Rispel, Cloete and Metcalf, 2015). The resultant feelings of inferiority plunges PLWHA into despair, while a misguided sense of superiority makes others think that they are immune to infection.

UNAIDS (2017, 9) stresses the importance of the impact of stigmatisation and discrimination about HIV/AIDS: "Stigma associated with HIV and the resulting discrimination can be as devastating as the illness itself; abandonment by spouse/ family, denial of medical services, lack of care and support and social ostracism". The

absence of the spirit of *Ubuntu* is rife. Stigmatisation and discrimination manifest themselves in such situations.

People living with HIV/AIDS experience a loss of social status that renders it more difficult for them to deal with the disease (Kamau, 2012). Most researchers concur that feelings of worthlessness, lost status and lost reputation are all adverse effects of stigma and discrimination (Avert, 2016; Peltzer, et al. 2015; Kamau, 2012; Van Dyk, 2012; UNAIDS, 2017; Aggleton, Yankah, and Crewe, 2011). These findings support the story shared by one teacher:

> *"After my husband passed away I could hear people say "it's obvious". It has been unbearable. Staff members have been avoiding me and back biting about my health, it has been unbearable".*

Among the commonly described aspects of stigma and discrimination in the data, is the perception that HIV/AIDS is a "death sentence":

> *"At first, I could see people around me discriminating me and I suffered from that stigma. Actions speak louder than words. It's really painful. I did not receive much support from the school level. I was sort of isolated whereas I expected my colleagues to sympathise with me".*

These high levels of stigma and discrimination cause teachers' effectiveness at work to diminish. Moreover, Squire (2013) argues that HIV/AIDS sufferers experience a sense of incompleteness in their everyday lives. Doyal (2016, 41) assert that people living with HIV/AIDS are treated like an "undifferentiated" group, whose sickness is self-inflicted and whose experiences are of little value. Stigma and discrimination are "shaped by pre-existing social traditions" as well as inequalities (Burchardt 2010, 4). This is evidence that stigma and discrimination can be minimised with care, support

and good leadership. People can be influenced to view problems from the perspective of those living with HIV/AIDS.

In addition, the literature highlights that teachers sometimes absent themselves from work because of the way they are discriminated against by their colleagues (Chan and Tsai 2017, 12). Burchardt (2010, 3) observes the following: "during the first phase of diagnosis, people are thrown into emotional pain and subjective uncertainty". Fear of death causes people to diagnose other people (UNAIDS, 2017). One teacher pointed out that:

> *"To be always suspected of having HIV/AIDS is traumatic. Other teachers gossip, which leads to stress and stress leads to depression to stroke and finally death".*

Stigma and discrimination have proven to be major challenges that make the lives of teachers living with HIV/AIDS unbearable. The entire school community is affected as well. Ultimately, stigma and discrimination can contribute to victims succumbing to the disease. Stigma and discrimination manifest themselves, in situations where teachers living with HIV/AIDS show the physical symptoms of HIV/AIDS.

Conclusion and recommendations

This study aimed to examine stigma and discrimination of teachers living with HIV/AIDS. Accordingly, conclusion drawn from the empirical data is that there are misconceptions about the causes of HIV/AIDS, for instance, promiscuous behaviour. From the inception, the causes of HIV/AIDS have been mainly attributed to indecent and wicked behaviour; labelled deviant and wrong.

Stigma and discrimination have proven to be a challenge that makes the lives of teachers living with HIV/AIDS unbearable and subsequently the entire school

community is affected. All the teacher participants indicated that they have expectations of protection and sympathy from their principals. Problems were identified by teachers living with HIV/AIDS relating to social death. These teachers maintain a low profile and they isolate themselves in addition to being isolated by their colleagues. They feel ostracised because their sense of belonging has been compromised by the most stigmatised disease. There were emanating challenges relating to deficient care and support. Teachers living with HIV/AIDS felt they were not protected from discrimination at work as well as being treated as individuals amid the sensitivity of HIV/AIDS.

The impact of stigma and discrimination is so profound that it results in the pandemic being made invisible, forcing people living with HIV/AIDS into hiding. Despite improvement in prevention and treatment measures since the discovery of the pandemic, stigmatisation and discrimination have continued to haunt those affected and infected by HIV/AIDS. The research findings showed that stigmatisation of and discrimination against teachers living with HIV/AIDS is exacerbated by stereotyped beliefs, fear associated with the disease's incurability, perceptions of teachers as sources of information and knowledge, and other social constructs around the pandemic. This results in these teachers being ostracised, labelled as inferior, and stripped of their status, all of which leaves them feeling worthlessness. It is widely stated in the literature that stigma and discrimination are socially constructed attributes that deeply discredit and reduce people from a whole to a discounted one.

The causes of HIV/AIDS have been mainly attributed to indecent and wicked behaviour that has been labelled deviant. Stereotyped beliefs lead to ostracism beliefs of people living with HIV/AIDS. Stigma and discrimination thickens the wall of silence and fear surrounding HIV/AIDS.

The cultural context where stigma exists subsequently leads to social disgrace whereby individuals or groups are isolated from the rest of the community and this affects one's quality of life. Therefore, it is imperative that teachers living with HIV/AIDS receive support rooted in human solidarity. The adoption of a human rights approach to HIV/AIDS goes a long way to eradicating stigma and discrimination which stand as barriers to testing and treatment services. School principals must take the lead to support teachers to do their jobs better. The reduction of stigma and discrimination in the workplace through programmes like the antiretroviral treatment, means that teachers are less likely to absent themselves from work.

Even though antiretroviral treatment has improved the health of PLWHA, HIV infection is still on the increase. The past is not past, despite of the new things, HIV/AIDS remains a problem. HIV/AIDS –related stigma and discrimination have not gone away.

Further research is required with the teachers living with HIV/AIDS to determine strategies that acquaint them with necessary skills and knowledge to handle HIV/AIDS-related stigma and discrimination. In this study, a small sample of teachers living with HIV/AIDS was used. A deeper understanding with the aim of addressing stigma and discrimination needs further exploration. Further studies should also focus on intervention programmes aimed at increasing knowledge and awareness of HIV/AIDS which could reduce HIV/AIDS –related stigma and discrimination. A bigger sample that covers other geographical areas could have provided a wider spectrum of experiences and views. This study was limited to Gauteng province, where the aim gain an in-depth understanding of the research phenomenon and not to generalise the results. Nevertheless, although generalisation is not permissible in qualitative research findings of this research study could be useful in similar contexts.

This research study confirms that stigmatisation of and discrimination against teachers living with HIV/AIDS is exacerbated by stereotyped beliefs, fear associated with the disease's incurability, perceptions of teachers as sources of information, and other social constructs around the pandemic. This results in these teachers being ostracised, labelled as inferior, and stripped of their status, all of which leaves them feeling worthlessness. With regard to this, it is widely stated in the literature that stigma and discrimination are socially constructed attributes that deeply discredit and reduce people from a whole to a discounted one. Since inception, the causes of HIV/AIDS have been mainly attributed to indecent and wicked behaviour that has been labelled deviant. Stereotyped beliefs lead to ostracism beliefs of people living with HIV/AIDS.

The study recommends intensification of raising consciousness about openness, trust and dialogue within families, work places and communities to overcome stigma and discrimination. Set up intervention programmes to reduce the myth of silence and shame around HIV/AIDS. In addition, continue educating societies on reducing new infections and supporting those who are infected.

It is anticipated that, through an enhanced understanding of the perceptions and experiences of teachers living with HIV/AIDS more informed decisions and policies can be made by principals, teachers, the Department of Education and the South African government.

References

Aggleton, P., Yankah, E. & Crewe, M. (2011). Education and HIV/AIDS – 30 years on. *Aids and Prevention*, 23(6), 495-507.

Aulette-Root, A., Aulette J.R. & Boonzaier, F. (2013). *South African Women living with HIV: Global lessons from local voices* Bloomington, Indiana University Press

Avert. (2016). HIV Stigma and discrimination [online]. Horsham: AVERT. Available from: https://www.avert.org/professionals/hiv-social-issues/stigma-discrimination

Bass, B. M. (1997). From Transactional to Transformational Leadership: Learning to share the vision. *Leadership: Understanding the dynamics of power and influence in organisations*, 318-333.

Begley, P.T. (2010). 'Leading with moral purpose: The place of ethics'. In: Bush, T., Bell, L. and Middlewood, D. (Eds.). *The Principles of Educational Leadership and Management*. 2nd ed. London: Sage. 31-55

Burchardt, M. (2010). Life in brackets: biological uncertainties of HIV positive women in South Africa. *Forum of Qualitative Social Research,* 11(1), 65-87.

Bush, T. (2008). *Leadership and Management in Education*. London: Sage.

Bush, T. (2012a). Authenticity in research: reliability, validity and triangulation. In: Briggs, A. R. J., Coleman, M. & Morrison, M. *Research Methods in Educational Leadership and Management.* (3rd ed.), London, Sage.

Bush, T. (2012b). *Leading and Managing People in Education*. London, Sage.

Campion, E. W. (2015). Treating millions for HIV – the adherence clubs of Khayelitsha. *New England Journal of Medicine*, 372(4), 301-303.

Chan, B. T., & Tsai, A. C. (2017). Personal contact with HIV-positive persons is associated with reduced HIV-related stigma: cross-sectional analysis of general

population surveys from 26 countries in sub-Saharan Africa. *Journal of the International AIDS Society*, *20*(1).

Chan, B. T., Tsai, A. C. & Siedner, M. J. (2015). HIV treatment scale-up and HIV related stigma in Sub-Saharan Africa: A longitudinal cross- country analysis. *American Journal of Public Health,* 105(8), 1581-1587.

Clandinin, D. J., Pushor, D. & Murray Orr, A. (2008). Navigating sites for narrative inquiry. *Journal of Teacher Education*, 1(58), 21-35.

Cohen, L., Manion, L. & Morrison, K. (2011). *Research Methods in Education*. (7th ed.), New York, NY: Routledge.

Cuca Y. P., Asher, A., Okonsky, J., Kaikura, A., Dawson-Rose, C. & Webel, A. (2017). HIV stigma and social capital in women living with HIV. *Journal of the Association of Nurses in AIDS Care,* 28(1), 45-54.

Dahlui, M., Azahar, N., Bulgiba, A., Zaki, R., Oche, O. M., Adekunjo, F. O., & Chinna, K. (2015). HIV/AIDS related stigma and discrimination against PLWHA in Nigerian population. *PloS one, 10*(12), e0143749.

Doyal, L. & Doyal, L. (2013)*. Living with HIV and dying with AIDS. Diversity, Inequality and Human Rights in the Global Pandemic.* London, Ashgate.

Given, L. M. (ed). (2008)*. The Sage Encyclopaedia of Qualitative Research Methods*. London, Sage.

Guba, E. G. & Lincoln, Y.S. (1989)*. Fourth Generation Evaluation*. London, Sage.

Held, V. (2006). *The Ethics of Care.* Oxford, Oxford University Press.

Johnson, S. M. & Naidoo, A. V. (2017). A psychoeducational approach for prevention of burnout among teachers dealing with HIV/AIDS in South Africa. *AIDS Care,* 29(1), 73-78.

Kamau, M. N. (2012). AIDS stigma and discrimination in Kenyan Public Schools. DPhil thesis. The University of Western Ontario, London, ON.

Kouses, J. M., & Posner, B. Z. (1995). *The Leadership Challenge. How to keep Getting Extraordinary Things Done in Organisations.* San Francisco, CA: Jossey-Bass.

Kvale, S. & Brinkman, S. (2009). *Interviews. Learning the Craft of Qualitative Research Interviewing.* (2nd ed.), Thousand Oaks, CA: Sage.

Leithwood, K., Tomlinson, D. & Gene, M. (1996). 'Transformational school leadership'. In: Leithwood K., Tomlinson, D. & Gene, M. (eds.), *International Handbook of Educational Leadership and Administration*. Holland: Kluwer Academic Publishers.

Mahabeer, P. (2008). School Principals' perceptions and responses to the HIV/AIDS pandemic in schools in the Eastern Cape. M.Ed. dissertation. Nelson Mandela Metropolitan University, Port Elizabeth.

Matthews, B. & Ross, L. (2010). *Research Methods. Practical Guide for Social Sciences.* London: Pearson.

McMillan, J. H. & Schumacher, S. (2010). *Research in Education. Evidence-Based Inquiry.* (7th ed.), Boston, MA: Allyn and Bacon.

Merriam, S. B. & Tisdell, E. J. (2015). *Qualitative Research: A Guide to Design and Implementation*. San Francisco, CA: Jossey-Bass.

Mertens, D. M. (2012). Ethics in qualitative research in education and social sciences. In: Lapan, S.D., Quartaroli, M.T. & Riemer, F.J. eds. *Qualitative Research. An Introduction to Methods and Designs.* San Francisco, CA: Jossey-Bass.19-36

Mfusi, B. J. (2011). *Needs and Challenges in Managing Educators with HIV/AIDS*. Pretoria, University of South Africa.

Moyo, Z. & Smit, B. (2017). The experiences of school principals of teachers living with HIV. *International Journal Management in Education*, 11(1), 46–58.

Newby, P. (2014). *Research Methods for Education*. Harlow, Pearson Education.

Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*. Berkeley, CA: University of California.

Noddings, N. (2002). *Starting at Home: Caring and Social Policy.* Berkeley, CA: University of California.

Peltzer, K., Szrek, H., Ramlagan, S., Leite, R. & Chao, L. (2015). Depression and social functioning among HIV- infected and uninfected persons in South Africa. *AIDS CARE,* 27(1), 41-46.

Perumal, J. C. (2015a). Responding with hospitality: Refugee children in the South African education system. *Education as Change.* Special Edition: Education for Social Change and Critical Praxis in South Africa.

Perumal, J. C. (2015b). Critical pedagogies of place: Educators' personal and professional experiences of social (in)justice. *Teaching and Teacher Education,* 45, 25-32.

Rispel, L. C., Cloete, A. & Metcalf, C. A. (2015). 'We keep her status to ourselves': Experiences of stigma and discrimination among HIV- discordant couples in South Africa, Tanzania and Ukraine. *SAHARA-J: Journal of Social Aspects of HIV/AIDS,* 12(1), 10-17.

Saldaña, J. (2011). *Fundamentals of Qualitative Research. Understanding Qualitative Research.* New York, NY: Oxford University Press.

Sander-Staudt, M. (2011). *Care Ethics. Internet Encyclopaedia of Philosophy*. Tempe, AZ: Arizona State University.

Siegel, H. (Ed.). (2009). *The Oxford Handbook of Philosophy of Education*. New York, NY: Oxford University Press.

South Africa. Gauteng Department of Education. (2016). *Statistical Overview of Ordinary and Special Education in Gauteng: SNAP Survey: 31 January 2016*. Johannesburg: Gauteng Department of Education.

Squire, C. (2013). *Living with HIV and ARVs: Three-Letter Lives.* London, Palgrave Macmillan.

Stake, R. E. (2010). *Qualitative Research. Studying how Things Work.* New York, NY: Guilford Press.

Statistics South Africa (2017). *Statistical Release P0302.* Pretoria: Statistics South Africa.

Tracy, S. J. (2010). Qualitative quality: eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.

Tracy, S. J. (2012). *Qualitative Research Methods. Collecting Evidence, Crafting Analysis, Communicating Impact*. West Sussex, Blackwell.

Tronto, J. (2010). *Moral Boundaries: A Political Argument for an Ethic of Care.* New York, NY: Routledge.

UNAIDS (2016). *HIV/AIDS in South Africa*. Geneva: UNAIDS.

UNAIDS (2017). ‘*Agenda for zero discrimination in health-care settings*’. Geneva: UNAIDS.

Van Dyk, A. (2012). *HIV/AIDS Education, Care and Counselling.* (5th ed). Cape Town, Phillippa van Aardt.

Wertz, F. J., Charmaz, K., McMullen, L.M., Josselson, R., Anderson, R. & McSpaden, E. (2011). *Five Ways of doing Qualitative Analysis*. London, Guilford Press.

Yin, R. K. (2011). *Qualitative Research from Start to Finish*. London: Guilford Press.

Zuma, K., Simbayi, L. C., Rehle, T., Mbelle, N., Zungu, N. P., Mthembu, J., North, A., Van Zyl, J., Jootse, S., Moyo, S., Wabiri, N., Maduna, V., Mabaso, M., Naidoo, I., Chasela, C., Chikovore, J. & the Educator Survey ii Study Team (2016). The health of educators in public schools in South Africa. Commissioned by the South African Department of Education.